**COLLABORATIVE CARE CONSULTANTS**

**Financial Policy 2025**

# REGISTRATION

Collaborative Care Consultants. LLC (CCC) must have complete and accurate information about you/your child to provide you with the most appropriate care, including processing your insurance claims. You must provide a driver’s license, government ID card or other official identification at every visit in addition to your insurance card(s) if applicable.

You will be asked to review your registration to ensure accuracy of all personal information. Please read and review this information carefully. Report any changes in address, insurance, e-mail, and/or telephone number immediately.

You will be asked to sign an Assignment of Benefits form, which allows us to bill your insurance company and receive payments directly from the insurance company. If you do not sign this form, we hold the right to consider you as **self-pay** and ask you to pay cash/credit card at the time of your visit.

# YOUR FINANCIAL POLICY

We rely on you to promptly pay your bills. You are ultimately responsible for all fees related to you/your child’s care. Any court ordered responsibility judgment is determined between the individuals involved, not in the clinic. Unless we are provided with court documents, we hold the presenting parent financially responsible for paying for the services.

We send you an itemized statement each month. **PAYMENT IS DUE UPON RECEIPT** of the statement. We accept cash, check, credit card (Visa, Mastercard, American Express, and Discover) or HSA debit cards.

# PAYMENT OF SERVICES OF LABORATORY CENTERS, IMAGING CENTERS OR SPECIALISTS OUTSIDE OF DCFC

From time-to-time laboratory tests are required to monitor the body’s response to treatment. CCC does not provide laboratory services on site. CCC providers are happy to furnish a referral and written order for laboratory testing to you or your preferred laboratory. Many tests can be done through your primary care clinic. If you have questions or concerns regarding bills for services by facilities other than CCC, please contact that facility.

# COPAY/DEDUCTIBLE/COINSURANCE

All co-payments are due when you check in for your visit. If you are unsure of your copay responsibilities, please contact your insurance company prior to your visit. We request that you reschedule your appointment if you are unable to pay your copay at the time of check-in. You are responsible for paying your deductible and coinsurance as determined by your insurance policy.

# PAYMENT PLAN

We know that payment for your healthcare may be difficult, and we will consider reasonable payment plans, provided you contact the clinic and set a plan for payment upon receipt of your bill. Please call our office if you would like to set up a payment plan.

# NO INSURANCE

We provide services to individuals who do not have health insurance, however, you **must notify us prior to your visit** so we can accurately estimate your costs. A sliding fee scale is available for those that are eligible. Determining eligibility for our sliding fee scale can take up to **two weeks**. Reduced service fees cannot be applied until an eligibility determination is made. For more information regarding our sliding fees scale please speak to your CCC provider.

**Minimum payments for sliding fees are due at the time of service.**

If you do not have insurance or your insurance company does not cover your services, we require a payment of **$100.00** for an urgent/sick visit or new patient visit, **50.00** for a routine medication visit for an established patient. These charges are introductory charges and subject to change. Any changes to your visit fee will be discussed with you prior to your visit. Payment for these services is required at check-in. If additional services are deemed necessary by the provider, during your examination, the fees for those services will be discussed with you prior to completing the services. You are expected to pay the fees for additional services at the time of your visit. Any services provided by a reference laboratory, imaging facility or pharmacy will be billed to you according to that facility’s policy and are not billed by CCC. It is your responsibility to contact outside providers (labs, imaging, etc.) for concerns you may have regarding their bills. We will make every effort to provide an estimate of outside service fees, if needed.

# QUESTIONS

If you have any questions regarding treatment or service fees, please discuss them with us promptly and frankly. We will make every effort to clarify information, and resolve concerns you may have. The clinic’s phone number is 651-209-8640.

By signing below, I am stating that I have read and understand Collaborative Care Consultant’s Financial Policy.

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**